P24.05

Health care expenditures of patients with major depressive disorder and post traumatic stress disorder

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Introduction: An estimated 50% of Americans are exposed to at least one traumatic event in a lifetime. Of those, 20% experience post-traumatic stress disorder (PTSD). Approximately 50% of patients with PTSD have comorbid major depression disorder. This study examined the cost differential between patients with major depressive disorder (MDD) only, PTSD only and patients with comorbid MDD and PTSD.

Methods: A retrospective study of patients with MDD and PTSD was performed using 1996 to 1999 claims from the MarketScan Database, with private sector health data from approximately 100 payers in the US. Three cohorts of patients were created: 1) patients with MDD (ICD-9-CM 296.2, 296.3, 300.4, or 311), 2) patients with PTSD (ICD-9-CM 309.81), and patients with both MDD and PTSD. Patients had to also have a prescription drug claim for an antidepressant within 30 days of diagnosis. During the 6 month follow-up, healthcare utilization and expenditures for inpatient, outpatient, emergency room, and outpatient drugs were calculated. Total expenditures were compared. ANOVA was used to assess the statistical significance of differences in expenditures.

Results: A total of 24,955 patients with fee-for-service health coverage were identified . Of those, 24,156 were diagnosed with MDD, 196 with PTSD, and 603 had co-occurring MDD and PTSD. The mean total expenditure for patients with MDD, PTSD, and MDD with PTSD were $3,407, $3,714, $5,723 respectively ($p<0.05$). PTSD was significantly associated with increased expenditures after stratifying for gender, age, and geographic region.

Conclusion: Costs associated with MDD and PTSD are substantial. The total health care expenditures of patients with PTSD were significantly higher than expenditures for patients with MDD alone. Patients with comorbid depression and PTSD had significantly increased expenditures than patients with one condition.

P24.06

Olanzapine or risperidone treatment initiation: SOHO Study Results

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Objectives: To compare initial use patterns for patients initiating treatment with olanzapine and risperidone in the Schizophrenia Outpatient Health Outcomes (SOHO) study.

Method: SOHO is a 3-year, prospective, Pan-European, observational study being conducted across 10 European countries. Dose, patient characteristics, and prescriptions for concomitant medications were compared for patients who initiated treatment with olanzapine or risperidone.

Results: Preliminary results were used to conduct comparisons of olanzapine (n=802) and risperidone (n=226) patients at baseline. Of patients who changed antipsychotic treatment, a larger proportion of olanzapine patients (40%) had received an atypical antipsychotic in the 6 months prior to treatment compared to risperidone patients (24%). Average doses upon treatment initiation were 10.1mg and 4.3mg for olanzapine and risperidone, respectively. A smaller proportion of the olanzapine patients received a concomitant anticholinergic (8%) compared to risperidone patients (19%).

Conclusions: Patients treated with olanzapine may be more likely to have a history indicative of greater severity of illness and/or treatment resistance compared to patients treated with risperidone. Despite low initial doses, risperidone patients were more likely to be treated with an anticholinergic for EPS than olanzapine patients.

P24.07

Schizophrenia treatment in Europe: country differences in the SOHO Study

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Objectives: To describe between country differences in schizophrenia treatment patterns in the Schizophrenia Outpatient Health Outcomes (SOHO) study.

Method: SOHO is a 3-year, prospective, Pan-European, observational study being conducted across 10 European countries. Patient characteristics in terms of resource utilisation, antipsychotics use patterns, and symptomatology were compared between countries.

Results: Preliminary results in the six month period before inclusion indicate that 36% of patients were admitted to hospital with figures ranging from 18% in Greece to 43% in Italy. Day-centre or day-hospital use was highest in Italy (52%of patients), and lowest in Greece (5%). Germany and Italy had the highest use of depot medications (more than 25% of patients in the previous 6 months). France and Spain had the highest use of atypical antipsychotics (above 40%). Rate of occurrence of EPS symptoms was highest in Greece. Germany and Greece also had the highest proportion of patients changing therapy due to side effects.

Conclusions: European countries show important differences in patterns of care for schizophrenia. The impact of these differences on long-term outcomes needs to be examined.

P24.08

Baseline results from SOHO: a pan-European, observational study

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Objectives: To describe baseline characteristics of patients included in the Schizophrenia Outpatient Health Outcomes study (SOHO).

Method: SOHO is a prospective, Pan-European, observational study being conducted across 10 European countries. Patients may be enrolled if, at the discretion of the treating clinician, they initiate antipsychotic medication in the outpatient setting. There will be 2 principal cohorts of approximately equal size: (1) patients who initiate olanzapine treatment; (2) patients who initiate non-olanzapine antipsychotic treatment.

Results: Preliminary results indicate that 74% of patients were rated as moderately or markedly ill, with negative symptoms being more prominent than positive. Thirty-seven percent of patients had taken an atypical antipsychotic in the previous six months and 16% were neuroleptic-naïve. Side effects were frequent, with 39% experiencing EPS, 12% tardive dyskinesia, and more than 50% with some form of sexual dysfunction. The most frequent reasons for medication change were lack of effectiveness and side effects.

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Conclusions: SOHO will provide unique data to study how patients with schizophrenia are treated in actual practice in Europe. Results indicate that antipsychotic side effects are frequent and a relevant reason for medication change.

P24.09

Hospitalisation and costs for schizophrenia relapse treatment in Germany

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Objective: To study hospital length of stay (LOS) and direct treatment cost for relapsing olanzapine and haloperidol-treated schizophrenia patients in Germany.

Method: Retrospective chart review of last hospitalisation due to schizophrenia relapse for a matched sample of patients matched on i) time since diagnosis; and ii) severity of symptoms.

Results: For the matched sample (n=136 matched pairs) olanzapine-treated patients had shorter inpatient hospital LOS, and a lower average direct treatment cost of 803 DM per patient. Due to significant patient differences regarding duration of intake of study medication prior to hospital admission, an exploratory re-matching was performed using this as re-matching criteria. For the re-matched sample (n=76 matched pairs) median LOS increased to about six weeks for haloperidol-treated patients, leading to an average lower cost of 3,517 DM for olanzapine-treated patient.

Conclusions: The results are consistent with results from randomised clinical trials in other countries in concluding that olanzapine is preferable to haloperidol in terms of the direct cost of treating schizophrenia.

P24.10

Economic aspects of bipolar disorder in Europe

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Objective: To quantify the societal costs associated with Bipolar Disorder (BPD) in Europe. This information is of importance to decision makers given restricted budgets and rising costs.

Method: A detailed search of information sources in 5 European countries (France, Germany, Italy, Spain and the UK). Information on prevalence, resource use and costs associated with BPD was collated.

Results: There was a paucity of evidence assessing the epidemiology, treatment patterns and especially service/resource use associated with BPD in Europe. Lost productivity was a substantial cost associated with the disorder. Hospitalisation accounted for the majority of service costs(1). Mania/hypomania episodes drive this hospitalisation cost, with hospitalisation rates four times those for BPD depression episodes. Medication impacted on current and future hospitalisation use and consequently on service costs(1).

Conclusion: BPD places a high burden on society's resources(2). Findings highlight the potential impact of mania medication choice on service costs.

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P24.11

Outcomes and cost's associated with different antipsychotic treatment

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The schizophrenic syndrome is a disabling condition and often begins in young adulthood. Between 50–70% of the cases have a chronic course with relapses in psychotic episodes, high morbidity and a mortality above the expected. In a time of scare resources and high national economic costs for schizophrenia, improved methods of treatment and efficient use of national resources has become increasingly important. Measuring cost-effectiveness of treatment requires inclusion of a broad evaluation of the outcome for patients concerning factors like treatment response, social functioning and occupational. The costs of schizophrenia do not only include costs for treatment of patients with a schizophrenic syndrome, but also the social and psychological costs experienced by their relatives.

New treatment usually results in an initial increase in costs but if outcome could be improved in patients as a result, this could produce long-term savings. In a naturalistic, retrospective study of 240 patients medical documents are studied during 2 years with respect to the following factors: days in hospital, prescribed psychotropic drugs, days in relapse, involuntary treatment and costs for legal procedures, children that need support, costs for support in patients homes, the amount of patients at work, the amount of patients with sick-leave or sick-pension, living circumstances and GAF. Patient prescribed classical antipsychotics per os, classical antipsychotic in depot-formulation, olanzapin or risperidon. Each group includes 60 patients. The result will be discussed with focus on costs and outcome.

P25. Internet in psychiatry

P25.01

Is the web-administered CIDI-SF equivalent to a human SCID-interview?

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The procedural validity of the Composite International Diagnostic Interview – short form (CIDI-SF) administered via an Internet web-page was examined and compared with an in-person interview (Structured Clinical Interview for DSM-IV Axis I Disorders, research version; SCID) for seven DSM-IV mental disorders: major depression, generalized anxiety, specific phobia, social phobia, agoraphobia, panic attack, and obsessive–compulsive disorder. The 53 participants completed a computerized interview (CIDI-SF) via a web page two days before the scheduled in-person interview (SCID). The agreement between CIDI-SF and SCID was generally low (Cohens Kappa <.40). However, the agoraphobia and obsessive–compulsive disorder modules had good specificity and sensitivity respectively. The CIDI-SF is not equivalent to a human SCID-interview, but can be used to screen for agoraphobia and obsessive–compulsive disorder. Furthermore, if the panic disorder

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